STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE Regulation

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX **File No. 90532-001**

Petitioner

v

American Community Mutual Insurance Company

Respondent

_____/

Issued and entered
this _____ day of August 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On June 23, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. After a preliminary review of the material submitted the Commissioner accepted the request on June 30, 2008.

The issue in this matter can be decided by analyzing the Petitioner's American Community Mutual Insurance Company (ACMIC) insurance policy, the contract that defines the Petitioner's health care coverage. The Commissioner reviews contractual issues under MCL 500.1911(7). No medical issues are presented requiring analysis by an independent medical review organization.

II
FACTUAL BACKGROUND

The Petitioner is covered under a fully insured individual policy underwritten by ACMIC. On December 19, 2007, the Petitioner underwent a colonoscopy at XXXXX Hospital. Tissue samples

from this procedure were sent to XXXXX, an out-of-network pathology provider. The amount charged for the pathology services was $1,020.00. ACMIC covered the service but applied the entire charge to the Petitioner's non-network deductible. The Petitioner was left responsible for the full amount charged.

The Petitioner appealed, asking ACMIC to cover the pathology services as if they were provided by an in-network provider. ACMIC reviewed the claims but upheld its decision and issued a final adverse determination dated May 30, 2008.

III
ISSUE

Was ACMIC correct when it applied the charge for the Petitioner's pathology services to the non-network deductible?

IV
ANALYSIS

Petitioner's Argument

The Petitioner states that at numerous times before and during his colonoscopy procedure, he requested that his care be provided by in-network physicians and facilities. Despite this, biopsy samples were sent to and read by an out-of-network pathologist. As a result the Petitioner received a bill of $1,020.00 from the pathologist.

The Petitioner argues that since he specifically requested that his care be performed by in-network providers and because he was never consulted as to which pathologist would interpret the biopsy, he should not be responsible for out-of-network charges.

American Community's Argument

ACMIC maintains that it correctly processed the Petitioner's claims. The Petitioner's policy has two levels of deductibles and benefits. When the provider is a member of the PPOM/Cofinity network, benefits are paid at 80% after a $1,000.00 deductible has been met. If the provider is not in the network, benefits are paid at 50% after a $2,000.00 deductible has been met. In this case, the Petitioner received services from a non-network provider so ACMIC applied the entire eligible

charge to his non-network deductible which had not yet been met.

ACMIC says the policy does not guarantee that an insured will be able to use a network provider in all situations -- it is very common for an insured to encounter non-network providers and that is the reason for the two levels of coverage. The policy has no provision that requires ACMIC to provide in-network benefits for services from a non-network provider except in an emergency.

ACMIC believes that it has paid the Petitioner's claims consistent with the provisions of the policy and is not required to pay any additional amount.

Commissioner's Review

The Commissioner has considered the arguments of both parties and the documentation presented, including the policy.

The Petitioner's policy has a $2,000.00 per person calendar year deductible for medical care services provided by a non-network provider. There is no dispute that the Petitioner's pathology services related to his December 19, 2007, colonoscopy were provided by a non-network provider, or that his non-network deductible had not been met at the time the service was performed.

Under the policy, claims are processed based on the network status of the provider; the policy allows no exception when the insured is not aware that a provider is not in the network. It is unfortunate that the Petitioner was not told that the pathologist was not in ACMIC's network. Nevertheless, the Commissioner can find nothing in the policy that would require ACMIC to cover services from a non-network pathologist at the network level given the facts of this case.

The Commissioner finds that ACMIC processed the Petitioner's claims correctly under the terms of the policy when it applied the $1,020.00 charges for his pathology services to his non-network deductible.

IV
ORDER

The Commissioner upholds American Community's adverse determination of May 30, 2008.

ACMIC correctly processed the Petitioner's claims for pathology services related to his December 19, 2007 colonoscopy under the terms and conditions of the policy.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, P. O. Box 30220, Lansing, MI 48909-7720.